

§ 435.1102

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§ 435.1102 General rules.

(a) The agency may provide services to children under age 19 during one or more periods of presumptive eligibility following a determination by a qualified entity that the child's estimated gross family income or, at the State's option, the child's estimated family income after applying simple disregards, does not exceed the applicable income standard.

(b) If the agency elects to provide services to children during a period of presumptive eligibility, the agency must—

(1) Provide qualified entities with application forms for Medicaid and information on how to assist parents, caretakers and other persons in completing and filing such forms;

(2) Establish procedures to ensure that qualified entities—

(i) Notify the parent or caretaker of the child at the time a determination regarding presumptive eligibility is made, in writing and orally if appropriate, of such determination;

(ii) Provide the parent or caretaker of the child with a regular Medicaid application form;

(iii) Within five working days after the date that the determination is made, notify the agency that a child is presumptively eligible;

(iv) For children determined to be presumptively eligible, notify the child's parent or caretaker at the time the determination is made, in writing and orally if appropriate, that—

(A) If a Medicaid application on behalf of the child is not filed by the last day of the following month, the child's presumptive eligibility will end on that last day; and

(B) If a Medicaid application on behalf of the child is filed by the last day of the following month, the child's presumptive eligibility will end on the day that a decision is made on the Medicaid application; and

(v) For children determined not to be presumptively eligible, notify the child's parent or caretaker at the time the determination is made, in writing and orally if appropriate—

(A) Of the reason for the determination; and

(B) That he or she may file an application for Medicaid on the child's behalf with the Medicaid agency;

(3) Provide all services covered under the plan, including EPSDT; and

(4) Allow determinations of presumptive eligibility to be made by qualified entities on a Statewide basis.

(c) The agency must adopt reasonable standards regarding the number of periods of presumptive eligibility that will be authorized for a child in a given time frame.

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AUTHORITY: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

SOURCE: 43 FR 45218, Sept. 29, 1978, unless otherwise noted.

Subpart A—General Provisions and Definitions

§ 436.1 Purpose and applicability.

This part sets forth, for Guam, Puerto Rico, and the Virgin Islands—

(a) The eligibility provisions that a State plan must contain;

(b) The mandatory and optional groups of individuals to whom Medicaid is provided under a State plan;

(c) The eligibility requirements and procedures that a Medicaid agency must use in determining and redetermining eligibility, and requirements it may not use; and

(d) The availability of FFP for providing Medicaid and for administering the eligibility provisions of the plan.

[43 FR 45218, Sept. 29, 1978, as amended at 44 FR 17939, Mar. 23, 1979]

§ 436.2 Basis.

This part implements the following sections of the Act and public laws that state requirements and standards for eligibility:

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402(a)(22) Eligibility of deemed recipients of AFDC who receive zero payments because of recoupment of overpayments.

402(a)(37) Eligibility of individuals who lose AFDC eligibility due to increased earnings.

414(g) Eligibility of certain individuals participating in work supplementation programs.

473(b) Eligibility of children in foster care and adopted children who are deemed AFDC recipients.

1902(a)(8) Opportunity to apply; assistance must be furnished promptly.

1902(a)(10) Required and optional groups.

1902(a)(12) Determination of blindness.

1902(a)(16) Out-of-State care for State residents.

1902(a)(17) Standards for determining eligibility; flexibility in the application of income eligibility standards.

1902(a)(19) Safeguards for simplicity of administration and best interests of recipients.

1902(a)(34) Three-month retroactive eligibility.

1902(a) (second paragraph after (47)) Eligibility despite increased monthly insurance benefits under title II.

1902(a)(55) Mandatory use of outstation locations other than welfare offices to receive and initially process applications of certain low-income pregnant women, infants, and children under age 19.

1902(b) Prohibited conditions for eligibility: Age requirements of more than 65 years;

State residence requirements excluding individuals who reside in the State; and

Citizenship requirement excluding United States citizens.

1902(e) Four-month continued eligibility for families ineligible because of increased hours or income from employment.

1902(e)(2) Minimum eligibility period for recipients enrolled in HMO.

1902(e)(3) Optional coverage of certain disabled children at home.

1902(e)(4) Eligibility of newborn children of Medicaid-eligible women.

1902(e)(5) Eligibility of pregnant women for extended coverage for a specified period after pregnancy ends.

1903(v) Payment for emergency services under Medicaid provided to aliens.

1905(a) (i)-(viii) List of eligible individuals.

1905(a) (clause following (21)) Prohibitions against providing Medicaid to certain institutionalized individuals.

1905(a) (second sentence) Definition of essential person.

1905(d)(2) Definition of resident of an intermediate care facility for the mentally retarded.

1905(n) Definition of qualified pregnant woman and child.

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1915(d) Home and community-based services for individuals age 65 or older.
 412(e)(5) of Immigration and Nationality Act—Eligibility of certain refugees.
 Pub. L. 93-66, section 230 Deemed eligibility of certain essential persons.
 Pub. L. 93-66, section 231 Deemed eligibility of certain persons in medical institutions.
 Pub. L. 93-66, section 232 Deemed eligibility of certain blind and disabled medically indigent persons.
 Pub. L. 96-272, section 310(b)(1) Continued eligibility of certain recipients of Veterans Administration pensions.
 Pub. L. 99-509, section 9406 Payment for emergency medical services provided to aliens.
 Pub. L. 99-603, section 201 Aliens granted legalized status under section 245A of the Immigration and Nationality Act (8 U.S.C. 1255a) may under certain circumstances be eligible for Medicaid.
 Pub. L. 99-603, section 302 Aliens granted legalized status under section 210 of the Immigration and Nationality Act may under certain circumstances be eligible for Medicaid (8 U.S.C. 1160).
 Pub. L. 99-603, section 303 Aliens granted legal status under section 210A of the Immigration and Nationality Act may under certain circumstances be eligible for Medicaid (8 U.S.C. 1161).

[52 FR 43072, Nov. 9, 1987; 52 FR 48438, Dec. 22, 1987, as amended at 55 FR 36820, Sept. 7, 1990; 55 FR 48609, Nov. 21, 1990; 57 FR 29155, June 30, 1992; 59 FR 48811, Sept. 23, 1994]

§ 436.3 Definitions and use of terms.

As used in this part—

AABD means aid to the aged, blind, and disabled under title XVI of the Act;

AB means aid to the blind under title X of the Act;

AFDC means aid to families with dependent children under title IV-A of the Act;

APTD means aid to the permanently and totally disabled under title XIV of the Act;

Categorically needy refers to families and children, aged, blind or disabled individuals, and pregnant women listed under subparts B and C of this part who are eligible for Medicaid. Subpart B of this part describes the mandatory eligibility groups who, generally, are receiving or deemed to be receiving cash assistance under the Act. These mandatory groups are specified in sections 1902(a)(10)(A)(i) and 1902(e) of the Act. Subpart C of this part describes the optional eligibility groups of individuals who, generally, meet the categorical

requirements that are the same as or less restrictive than those of the cash assistance programs but are not receiving cash payments. These optional groups are specified in sections 1902(a)(10)(A)(ii) and 1902(e) of the Act.

Families and children refers to eligible members of families with children who are financially eligible under AFDC or medically needy rules and who are deprived of parental support or care as defined under the AFDC program (see 45 CFR 233.90; 233.100). In addition, this group includes individuals under age 21 who are not deprived of parental support or care but who are financially eligible under AFDC or medically needy rules (see optional coverage group, § 436.222);

Medically needy means families, children, aged, blind, or disabled individuals, and pregnant women listed in subpart D of this part who are not listed in subparts B and C of this part as categorically needy but who may be eligible for Medicaid under this part because their income and resources are within limits set by the State under its Medicaid plan (including persons whose income and resources fall within these limits after their incurred expenses for medical or remedial care are deducted). (Specific financial requirements for determining eligibility of the medically needy appear in subpart I of this part.)

OAA means old age assistance under title I of the Act;

OASDI means old age, survivors, and disability insurance under Title II of the Act.

Optional targeted low-income child means a child under age 19 who meets the financial and categorical standards described below.

(1) *Financial need.* An optional targeted low-income child:

(i) Has a family income at or below 200 percent of the Federal poverty line for a family of the size involved;

(ii) Resides in a State with no Medicaid applicable income level (as defined in § 457.10 of this chapter); or,

(iii) Resides in a State that has a Medicaid applicable income level (as defined in § 457.10) and has family income that either:

(A) Exceeds the Medicaid applicable income level for the age of such child, but not by more than 50 percentage

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points (expressed as a percentage of the Federal poverty line); or

(B) Does not exceed the income level specified for such child to be eligible for medical assistance under the policies of the State plan under title XIX on June 1, 1997.

(2) *No other coverage and State maintenance of effort.* An optional targeted low-income child is not covered under a group health plan or health insurance coverage, or would not be eligible for Medicaid under the policies of the State plan in effect on March 31, 1997; except that, for purposes of this standard—

(i) A child shall not be considered to be covered by health insurance coverage based on coverage offered by the State under a program in operation prior to July 1, 1997 if that program received no Federal financial participation;

(ii) A child shall not be considered to be covered under a group health plan or health insurance coverage if the child did not have reasonable geographic access to care under that coverage.

(3) For purposes of this section, policies of the State plan under title XIX plan include policies under a Statewide demonstration project under section 1115(a) of the Act other than a demonstration project that covered an expanded group of eligible children but that either—

(i) Did not provide inpatient hospital coverage; or

(ii) Limited eligibility to children previously enrolled in Medicaid, imposed premiums as a condition of initial or continued enrollment, and did not impose a general time limit on eligibility.

[43 FR 45218, Sept. 29, 1978, as amended at 45 FR 24887, Apr. 11, 1980; 46 FR 47989, Sept. 30, 1981; 58 FR 4934, Jan. 19, 1993; 66 FR 2668, Jan. 11, 2001]

§ 436.10 State plan requirements.

A State plan must—

(a) Provide that the requirements of this part are met; and

(b) Specify the groups to whom Medicaid is provided, as specified in subparts B, C, and D of this part, and the conditions of eligibility for individuals in those groups.

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Subpart B—Mandatory Coverage of the Categorically Needy

§ 436.100 Scope.

This subpart prescribes requirements for coverage of categorically needy individuals.

§ 436.110 Individuals receiving cash assistance.

(a) A Medicaid agency must provide Medicaid to individuals receiving cash assistance under OAA, AFDC, AB, APTD, or AABD.

(b) For purposes of this section, an individual is receiving cash assistance if his needs are considered in determining the amount of the payment. This includes an individual whose presence in the home is considered essential to the well-being of a recipient under the State's plan for OAA, AFDC, AB, APTD, or AABD if that plan were as broad as allowed under the Act for FFP.

§ 436.111 Individuals who are not eligible for cash assistance because of a requirement not applicable under Medicaid.

(a) The agency must provide Medicaid to individuals who would be eligible for OAA, AB, APTD, or AABD except for an eligibility requirement used in those programs that is specifically prohibited under title XIX of the Act.

(b) The agency also must provide Medicaid to:

(1) Individuals denied AFDC solely because of policies requiring the deeming of income and resources of the following individuals who are not included as financially responsible relatives under section 1902(a)(17)(D) of the Act:

- (i) Stepparents who are not legally liable for support of stepchildren under a State law of general applicability;
 - (ii) Grandparents
 - (iii) Legal guardians;
 - (iv) Aliens sponsors who are not organizations; and
 - (v) Siblings.
- (2) [Reserved]

[58 FR 4934, Jan. 19, 1993, as amended at 59 FR 43053, Aug. 22, 1994]

§ 436.112 Individuals who would be eligible for cash assistance except for increased OASDI under Pub. L. 92-336 (July 1, 1972).

The agency must provide Medicaid to individuals who meet the following conditions:

(a) In August 1972, the individual was entitled to OASDI and—

(1) He was receiving cash assistance; or

(2) He would have been eligible for cash assistance if he had applied, and the Medicaid plan covered this optional group; or

(3) He would have been eligible for cash assistance if he were not in a medical institution or intermediate care facility, and the Medicaid plan covered this optional group.

(b) The individual would currently be eligible for cash assistance except that the increase in OASDI under Pub. L. 92-336 raised his income over the limit allowed under the cash assistance program. This includes an individual who—

(1) Meets all current requirements for cash assistance except for the requirement to file an application; or

(2) Would meet all current requirements for cash assistance if he were not in a medical institution or intermediate care facility, and the Medicaid plan covers this optional group.

§ 436.114 Individuals deemed to be receiving AFDC.

(a) The Medicaid agency must provide Medicaid to individuals deemed to be receiving AFDC, as specified in this section.

(b) The State must deem individuals to be receiving AFDC who are denied a cash payment from the title IV-A State agency solely because the amount of the AFDC payment would be less than \$10.

(c) The State may deem participants in a work supplementation program to be receiving AFDC under section 414(g) of the Act. This section permits States, for purposes of title XIX, to deem an individual and any child or relative of the individual (or other individual living in the same household) to be receiving AFDC, if the individual—

(1) Participates in a State-operated work supplementation program under section 414 of the Act; and

(2) Would be eligible for an AFDC cash payment if the individual were not participating in the work supplementation program.

(d) The State must deem to be receiving AFDC those individuals who are denied AFDC payments from the title IV-A State agency solely because that agency is recovering an overpayment.

(e) The State must deem to be receiving AFDC individuals described in section 473(a)(1) of the Act—

(1) For whom an adoption assistance agreement is in effect under title IV-E of the Act, whether or not adoption assistance is being provided or an interlocutory or other judicial decree of adoption has been issued; or

(2) For whom foster care maintenance payments are made under title IV-E of the Act.

(f) The State must deem an individual to be receiving AFDC if a new collection or increased collection of child or spousal support under title IV-D of the Social Security Act results in the termination of AFDC eligibility in accordance with section 406(h) of the Social Security Act. States must continue to provide Medicaid for four consecutive calendar months, beginning with the first month of AFDC ineligibility, to each dependent child and each relative with whom such a child is living (including the eligible spouse of such relative as described in section 406(b) of the Social Security Act) who:

(1) Becomes ineligible for AFDC on or after August 16, 1984; and

(2) Has received AFDC for at least three of the six months immediately preceding the month in which the individual becomes ineligible for AFDC; and

(3) Becomes ineligible for AFDC wholly or partly as a result of the initiation of or an increase in the amount of a child or spousal support collection under title IV-D.

(g)(1) Except as provided in paragraph (g)(2) of this section, individuals who are eligible for extended Medicaid lose this coverage if they move to another State during the 4-month period. However, if they move back to and re-establish residence in the State in

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which they have extended coverage, they are eligible for any of the months remaining in the 4-month period in which they are residents of the State.

(2) If a State has chosen in its State plan to provide Medicaid to non-residents, the State may continue to provide the 4-month extended benefits to individuals who have moved to another State.

(h) For purposes of paragraph (f) of this section:

(1) The new collection or increased collection of child or spousal support results in the termination of AFDC eligibility when it actively causes or contributes to the termination. This occurs when:

(i) The change in support collection in and of itself is sufficient to cause ineligibility. This rule applies even if the support collection must be added to other, stable income. It also applies even if other independent factors, alone or in combination with each other, might simultaneously cause ineligibility; or

(ii) The change in support contributes to ineligibility but does not by itself cause ineligibility. Ineligibility must result when the change in support is combined with other changes in income or changes in other circumstances and the other changes in income or circumstances cannot alone or in combination result in termination without the change in support.

(2) In cases of increases in the amounts of both the support collections and earned income, eligibility under this section does not preclude eligibility under 45 CFR 233.20(a)(14) or section 1925 of the Social Security Act (which was added by section 303(a) of the Family Support Act of 1988 (42 U.S.C. 1396r-6)). Extended periods resulting from both an increase in the amount of the support collection and from an increase in earned income must run concurrently.

[46 FR 47989, Sept. 30, 1981, as amended at 52 FR 43072, Nov. 9, 1987; 52 FR 48438, Dec. 22, 1987; 55 FR 48610, Nov. 21, 1990; 59 FR 59377, Nov. 17, 1994]

§ 436.116 Families terminated from AFDC because of increased earnings or hours of employment.

(a) If a family loses AFDC solely because of increased income from employment or increased hours of employment, the agency must continue to provide Medicaid for 4 months to all members of the family if—

(1) The family received AFDC in any 3 or more months during the 6-month period immediately before the month in which it became ineligible for AFDC; and

(2) At least one member of the family is employed throughout the 4-month period, although this need not be the same member for the whole period.

(b) The 4 calendar month period begins on the date AFDC is terminated. If AFDC benefits are terminated retroactively, the 4 calendar month period also begins retroactively with the first month in which AFDC was erroneously paid.

[43 FR 45218, Sept. 29, 1978, as amended at 45 FR 24887, Apr. 11, 1980]

§ 436.118 Children for whom adoption assistance or foster care maintenance payments are made.

The agency must provide Medicaid to children for whom adoption assistance or foster care maintenance payments are made under title IV-E of the Act.

[47 FR 28656, July 1, 1982]

§ 436.120 Qualified pregnant women and children who are not qualified family members.

(a) The Medicaid agency must provide Medicaid to a pregnant woman whose pregnancy has been medically verified and who—

(1) Would be eligible for an AFDC cash payment (or would be eligible for an AFDC cash payment if coverage under the State's AFDC plan included the AFDC-unemployed parents program) if her child had been born and was living with her in the month of payment;

(2) Is a member of a family that would be eligible for an AFDC cash

payment if the State's AFDC plan included an AFDC-unemployed parents program; or

(3) Meets the income and resource requirements of the State's approved AFDC plan. In determining whether the woman meets the AFDC income and resource requirements, the unborn child or children are considered members of the household, and the woman's family is treated as though deprivation exists.

(b) The provisions of paragraphs (a) (1) and (2) of this section are effective October 1, 1984. The provisions of paragraph (a)(3) of this section are effective July 1, 1986.

(c) The agency must provide Medicaid to children who meet all of the following criteria:

(1) They are born after September 30, 1983;

(2) Effective October 1, 1988, they are under age 6 (or if designated by the State, any age that exceeds age 6 but does not exceed age 8), and effective October 1, 1989 they are under age 7 (or if designated by the State, any age that exceeds age 7 but does not exceed age 8); and

(3) They meet the income and resource requirements of the State's approved AFDC plan.

[52 FR 43072, Nov. 9, 1987, as amended at 55 FR 48610, Nov. 21, 1990; 58 FR 48614, Sept. 17, 1993]

§ 436.121 Qualified family members.

(a) *Definition.* A *qualified family member* is any member of a family, including pregnant women and children eligible for Medicaid under § 436.120 of this subpart, who would be receiving AFDC cash benefits on the basis of the unemployment of the principal wage earner under section 407 of the Act had the State not chosen to place time limits on those benefits as permitted under section 407(b)(2)(B)(i) of the Act.

(b) *State plan requirement.* The State plan must provide that the State makes Medicaid available to any individual who meets the definition of "qualified family member" as specified in paragraph (a) of this section.

(c) *Applicability.* The provisions in this section are applicable from October 1, 1992, through September 30, 1998.

[58 FR 48614, Sept. 17, 1993]

§ 436.122 Pregnant women eligible for extended coverage.

(a) The Medicaid agency must provide categorically needy Medicaid eligibility for an extended period following termination of pregnancy to women who, while pregnant, applied for, were eligible for, and received Medicaid services on the day that their pregnancy ends. This period extends from the last day of pregnancy through the end of the month in which a 60-day period, beginning on the last day of the pregnancy, ends. Eligibility must be provided, regardless of changes in the woman's financial circumstances that may occur within this extended period. These pregnant women are eligible for the extended period for all services under the plan that are pregnancy-related (as defined in § 440.210(c)(1) of this subchapter).

(b) The provisions of paragraph (a) of this section apply to Medicaid furnished on or after April 7, 1986.

[55 FR 48610, Nov. 21, 1990]

§ 436.124 Newborn children.

(a) The Medicaid agency must provide categorically needy Medicaid eligibility to a child born to a woman who is eligible for and receiving Medicaid on the date of the child's birth. The child is deemed to have applied and been found eligible for Medicaid on the date of birth and remains eligible as categorically needy for one year so long as the woman remains eligible and the child is a member of the woman's household. If the mother's basis of eligibility changes to medically needy, the child is eligible as medically needy under § 436.301(b)(1)(iii).

(b) The requirements under paragraph (a) of this section apply to children born on or after October 1, 1984.

[52 FR 43073, Nov. 9, 1987; 52 FR 48438, Dec. 22, 1987]

§ 436.128 Coverage for certain qualified aliens.

The agency must provide the services necessary for the treatment of an

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emergency medical condition as defined in § 440.255(c) of this chapter to those aliens described in § 436.406(c) of this subpart.

[55 FR 36820, Sept. 7, 1990]

Subpart C—Options for Coverage as Categorically Needy

§ 436.200 Scope.

This subpart specifies options for coverage of individuals as categorically needy.

§ 436.201 Individuals included in optional groups.

(a) The agency may choose to cover as optional categorically needy any group or groups of the following individuals who are not receiving cash assistance and who meet the appropriate eligibility criteria for groups specified in the separate sections of this subpart:

(1) Aged individuals (65 years of age or older);

(2) Blind individuals (as defined in § 436.530);

(3) Disabled individuals (as defined in § 436.541);

(4) Individuals under age 21 (or, at State option), under age 20, 19, or 18) or reasonable classifications of these individuals;

(5) Specified relatives under section 406(b)(1) of the Act who have in their care an individual who is determined to be dependent) as specified in § 436.510;

(6) Pregnant women; and

(7) Essential spouses specified under § 436.230.

(b) If the agency provides Medicaid to any individual in an optional group specified in paragraph (a) of this section, the agency must provide Medicaid to all individuals who apply and are found eligible to be members of that group.

[58 FR 4934, Jan. 19, 1993]

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OPTIONS FOR COVERAGE OF FAMILIES AND CHILDREN AND AGED, BLIND, AND DISABLED INDIVIDUALS, INCLUDING PREGNANT WOMEN

§ 436.210 Individuals who meet the income and resource requirements of the cash assistance programs.

The agency may provide Medicaid to any group or groups of individuals specified under § 436.201(a)(1), (a)(2), (a)(3), (a)(5), and (a)(6) who are not mandatory categorically needy and who meet the income and resource requirements of the appropriate cash assistance program for their status (that is, OAA, AFDC, AB, APTD, or AABD).

[58 FR 4935, Jan. 19, 1993]

§ 436.211 Individuals who would be eligible for cash assistance if they were not in medical institutions.

The agency may provide Medicaid to any group or groups of individuals specified in § 436.201(a) who are in title XIX reimbursable medical institutions and who:

(a) Are ineligible for the cash assistance program appropriate for their status (that is, OAA, AFDC, AB, APTD, or AABD) because of lower income standards used under the program to determine eligibility for institutionalized individuals; but

(b) Would be eligible for aid or assistance under the State's approved plan under OAA, AFDC, AB, APTD, or AABD if they were not institutionalized.

[58 FR 4935, Jan. 19, 1993]

§ 436.212 Individuals who would be eligible for cash assistance if the State plan for OAA, AFDC, AB, APTD, or AABD were as broad as allowed under the Act.

(a) The agency may provide Medicaid to any group or groups of individuals specified under § 436.201(a) who:

(1) Would be eligible for OAA, AFDC, AB, APTD, or AABD if the State's plan under those programs included individuals whose coverage under title I, IV-A, X, XIV, or XVI of the Act is optional (for example, the agency may provide Medicaid to individuals who are 18

years of age and who are attending secondary school full-time and are expected to complete their education before age 19, even though the State's AFDC plan does not include them); or

(2) Would qualify for OAA, AFDC, AB, APTD, or AABD if the State's plan under those programs did not contain eligibility requirements more restrictive than, or in addition to, those required under the appropriate title of the Act. (For example, the agency may provide Medicaid to individuals who would meet the Federal definition of disability, 45 CFR 233.80, but who do not meet the State's more restrictive definitions.)

(b) The agency may cover one or more optional groups under any of the titles of the Act without covering all such groups.

[43 FR 45218, Sept. 29, 1978, as amended at 45 FR 24887, Apr. 11, 1980; 46 FR 47990, Sept. 30, 1981; 58 FR 4935, Jan. 19, 1993]

§ 436.217 Individuals receiving home and community-based services.

The agency may provide Medicaid to any group or groups of individuals in the community who meet the following requirements:

(a) The group would be eligible for Medicaid if institutionalized.

(b) In the absence of home and community-based services under a waiver granted under part 441—

(1) Subpart G of this subchapter, the group would otherwise require the level of care furnished in a hospital, NF, or an ICF/MR; or

(2) Subpart H of this subchapter, the group would otherwise require the level of care furnished in a NF and are age 65 or older.

(c) The group receives the waived services.

[57 FR 29155, June 30, 1992]

§ 436.220 Individuals who would meet the income and resource requirements under AFDC if child care costs were paid from earnings.

(a) The agency may provide Medicaid to any group or groups of individuals specified under § 436.201(a)(4), (a)(5), and (a)(6) who would meet the income and resource requirements under the State's AFDC plan if their work-related child care costs were paid from

their earnings rather than by a State agency as a service expenditure.

(b) The agency may use this option only if the State's AFDC plan deducts work-related child care costs from income to determine the amount of AFDC.

[43 FR 45218, Sept. 29, 1978, as amended at 58 FR 4935, Jan. 19, 1993]

§ 436.222 Individuals under age 21 who meet the income and resource requirements of AFDC.

(a) The agency may provide Medicaid to individuals under age 21 (or at State option, under age 20, 19, or 18) or reasonable categories of these individuals as specified in paragraph (b) of this section, who are not receiving cash assistance but who meet the income and resource requirements of the State's approved AFDC plan.

(b) The agency may cover all individuals described in paragraph (a) of this section or reasonable classifications of those individuals. Examples of reasonable classifications are as follows:

(1) Individuals in foster homes or private institutions for whom a public agency is assuming a full or partial financial responsibility. If the agency covers these individuals, it may also provide Medicaid to individuals of the same age in foster homes or private institutions by private nonprofit agencies.

(2) Individuals in adoptions subsidized in full or in part by a public agency.

(3) Individuals in nursing facilities when nursing facility services are provided under the plan to individuals within the age group selected under this provision. If the agency covers these individuals, it may also provide Medicaid to individuals in intermediate care facilities for the mentally retarded.

(4) Individuals receiving active treatment as inpatients in psychiatric facilities or programs, if inpatient psychiatric services for individuals under 21 are provided under the plan.

[46 FR 47990, Sept. 30, 1981, as amended at 58 FR 4935, Jan. 19, 1993]

§ 436.224

§ 436.224 Individuals under age 21 who are under State adoption assistance agreements.

(a) The agency may provide Medicaid to individuals under the age of 21 (or, at State option, age 20, 19, or 18)—

(1) For whom an adoption agreement (other than an agreement under title IV-E) between the State and adoptive parent(s) is in effect;

(2) Who, the State agency responsible for adoption assistance has determined, cannot be placed with adoptive parents without Medicaid because the child has special needs for medical or rehabilitative care; and

(3) Who meet either of the following:

(i) Were eligible for Medicaid under the State plan before the adoption agreement was entered into; or

(ii) Would have been eligible for Medicaid before the adoption agreement was entered into, if the eligibility standards and methodologies of the foster care program were used without employing the threshold title IV-A eligibility determination.

(b) For adoption assistance agreements entered into before April 7, 1986—

(1) The agency must deem the requirements of paragraph (a)(1) and (2) of this section to be met if the State adoption assistance agency determines that—

(i) At the time of the adoption placement, the child had special needs for medical or rehabilitative care that made the child difficult to place; and

(ii) There is in effect an adoption assistance agreement between the State and the adoptive parent(s).

(2) The agency must deem the requirements of paragraph (a)(3) of this section to be met if the child was found by the State to be eligible for Medicaid before the adoption assistance agreement was entered into.

[55 FR 48610, Nov. 21, 1990]

§ 436.229 Optional targeted low-income children.

The agency may provide Medicaid to—

(a) All individuals under age 19 who are optional targeted low-income children as defined in § 436.3; or

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(b) Reasonable categories of these individuals.

[66 FR 2668, Jan. 11, 2001]

OPTIONS FOR COVERAGE OF THE AGED, BLIND, AND DISABLED

§ 436.230 Essential spouses of aged, blind, or disabled individuals receiving cash assistance.

The agency may provide Medicaid to the spouse of an individual receiving OAA, AB, APTD, or AABD, if—

(a) The spouse is living with the individual receiving cash assistance;

(b) The cash assistance agency has determined that the spouse is essential to the well-being of the individual and has considered the spouse's needs in determining the amount of cash assistance provided to the individual.

Subpart D—Optional Coverage of the Medically Needy

§ 436.300 Scope.

This subpart specifies the option for coverage of medically needy individuals.

§ 436.301 General rules.

(a) A Medicaid agency may provide Medicaid to individuals specified in this subpart who:

(1) Either:

(i) Have income that meets the standard in § 436.811; or

(ii) If their income is more than allowed under the standard, have incurred medical expenses at least equal to the difference between their income and the applicable income standards; and

(2) Have resources that meet the standard in §§ 436.840 and 436.843.

(b) If the agency chooses this option, the following provisions apply:

(1) The agency must provide Medicaid to the following individuals who meet the requirements of paragraph (a) of this section:

(i) All pregnant women during the course of their pregnancy who, except for income and resources, would be eligible for Medicaid as mandatory or optional categorically needy under subparts B and C of this part;

(ii) All individuals under 18 years of age who, except for income and resources, would be eligible for Medicaid as mandatory categorically needy under subpart B of this part;

(iii) All newborn children born on or after October 1, 1984, to a woman who is eligible as medically needy and receiving Medicaid on the date of the child's birth. The child is deemed to have applied and been found eligible for Medicaid on the date of birth and remains eligible as medically needy for one year so long as the woman remains eligible and the child is a member of the woman's household. If the woman's basis of eligibility changes to categorically needy, the child is eligible as categorically needy under § 436.124. The woman is considered to remain eligible if she meets the spend-down requirements in any consecutive budget period following the birth of the child.

(iv) Women who, while pregnant, applied for, were eligible for, and received Medicaid services as medically needed on the day that their pregnancy ends. The agency must provide medically needy eligibility to these women for an extended period following termination of pregnancy. This period begins on the last day of the pregnancy and extends through the end of the month in which a 60-day period following termination of pregnancy ends. Eligibility must be provided, regardless of changes in the women's financial circumstances that may occur within this extended period. These women are eligible for the extended period for all services under the plan that are pregnancy-related (as defined in § 440.210(c)(1) of this subchapter).

(2) The agency may provide Medicaid to any or all of the following groups of individuals:

- (i) Individuals under age 21 (§ 436.308).
- (ii) Specified relatives (§ 436.310).
- (iii) Aged (§ 436.320).
- (iv) Blind (§ 436.321).
- (v) Disabled (§ 436.322).

(3) If the agency provides Medicaid to any individual in a group specified in paragraph (b)(2) of this section, the agency must provide Medicaid to all

individuals eligible to be members of that group.

[46 FR 47990, Sept. 30, 1981; 46 FR 54743, Nov. 4, 1981, as amended at 52 FR 43073, Nov. 9, 1987; 55 FR 48610, Nov. 21, 1990; 58 FR 4935, Jan. 19, 1993]

§ 436.308 Medically needy coverage of individuals under age 21.

(a) If the agency provides Medicaid to the medically needy, it may provide Medicaid to individuals under age 21 (or at State option, under age 20, 19, or 18) as specified in paragraph (b) of this section:

(1) Who would not be covered under the mandatory medically needy group of individuals under 18 under § 436.301(b)(1)(ii); and

(2) Who meet the income and resource requirements of subpart I of this part.

(b) The agency may cover all individuals in paragraph (a) of this section or individuals in reasonable classifications. Examples of reasonable classifications are as follows:

(1) Individuals in foster homes or private institutions for whom a public agency is assuming a full or partial financial responsibility. If the agency covers these individuals, it may also provide Medicaid to individuals placed in foster homes or private institutions by private nonprofit agencies.

(2) Individuals in adoptions subsidized in full or in part by a public agency.

(3) Individuals in nursing facilities when nursing facility services are provided under the plan to individuals within the age group selected under this provision. When the agency covers such individuals, it may also provide Medicaid to individuals in intermediate care facilities for the mentally retarded.

(4) Individuals receiving active treatment as inpatients in psychiatric facilities or programs, if inpatient psychiatric services for individuals under 21 are provided under the plan.

[46 FR 47990, Sept. 30, 1981, as amended at 58 FR 4935, Jan. 19, 1993]

§ 436.310

§ 436.310 Medically needy coverage of specified relatives.

(a) If the agency provides for the medically needy, it may provide Medicaid to specified relatives, defined in paragraph (b) of this section, who meet the income and resource requirements of subpart I of this part.

(b) *Specified relatives* means individuals who:

(1) Are listed under section 406(b)(1) of the Act and in 45 CFR 233.90(c)(1)(v)(A); and

(2) Have in their care an individual who is determined to be (or would, if needy, be) dependent, as specified in § 436.510.

[58 FR 4936, Jan. 19, 1993]

§ 436.320 Medically needy coverage of the aged.

If the agency provides Medicaid to the medically needy, it may provide Medicaid to individuals who—

(a) Are 65 years of age and older, as provided for in § 436.520; and

(b) Meet the income and resource requirements of subpart I of this part.

[46 FR 47991, Sept. 30, 1981]

§ 436.321 Medically needy coverage of the blind.

If the agency provides Medicaid to the medically needy, it may provide Medicaid to blind individuals who meet—

(a) The requirements for blindness, as specified in §§ 436.530 and 436.531; and

(b) The income and resource requirements of subpart I of this part.

[46 FR 47991, Sept. 30, 1981]

§ 436.322 Medically needy coverage of the disabled.

If the agency provides Medicaid to the medically needy, it may provide Medicaid to disabled individuals who meet—

(a) The requirements for disability, as specified in §§ 436.540 and 436.541; and

(b) The income and resource requirements of subpart I of this part.

[46 FR 47991, Sept. 30, 1981]

§ 436.330 Coverage for certain aliens.

If an agency provides Medicaid to the medically needy, it must provide the

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services necessary for the treatment of an emergency medical condition, as defined in § 440.255(c) of this chapter to those aliens described in § 436.406(c) of this subpart.

[55 FR 36820, Sept. 7, 1990]

Subpart E—General Eligibility Requirements

§ 436.400 Scope.

This subpart prescribes general requirements for determining the eligibility of both categorically needy and medically needy individuals specified in subparts B, C, and D of the part.

§ 436.401 General rules.

(a) The agency may not impose any eligibility requirement that is prohibited under title XIX.

(b) The agency must base any optional group covered under subparts B and C of this part on reasonable classifications that do not result in arbitrary or inequitable treatment of individuals and groups and are consistent with the objectives of title XIX.

(c) The agency must not use requirements for determining eligibility for optional coverage groups that are more restrictive than those used under the State plans for OAA, AFDC, AB, APTD, or AABD.

§ 436.402 [Reserved]

§ 436.403 State residence.

(a) *Requirement.* The agency must provide Medicaid to eligible residents of the State, including residents who are absent from the State. The conditions under which payment for service is provided to out-of-State residents are set forth in § 431.52 of this chapter.

(b) *Definition.* For purposes of this section—*Institution* has the same meaning as *Institution* and *Medical institution*, as defined in § 435.1009 of this chapter. For purposes of State placement, the term also includes “foster care homes”, licensed as set forth in 45 CFR 1355.20, and providing food, shelter and supportive services to one or more persons unrelated to the proprietor.

(c) *Incapability of indicating intent.* For purposes of this section, an individual is considered incapable of indicating intent if the individual—

(1) Has an I.Q. of 49 or less or has a mental age of 7 or less, based on tests acceptable to the mental retardation agency in the State;

(2) Is judged legally incompetent; or

(3) Is found incapable of indicating intent based on medical documentation obtained from a physician, psychologist, or other person licensed by the State in the field of mental retardation.

(d) *Who is a State resident.* A resident of a State is any individual who:

(1) Meets the conditions in paragraphs (e) through (h) of this section; or

(2) Meets the criteria specified in an interstate agreement under paragraph (j) of this section.

(e) *Placement by a State in an out-of-state institution—*(1) *General rule.* Any agency of the State, including an entity recognized under State law as being under contract with the State for such purposes, that arranges for an individual to be placed in an institution located in another State, is recognized as acting on behalf of the State in making a placement. The State arranging or actually making the placement is considered as the individual's State of residence.

(2) Any action beyond providing information to the individual and the individual's family would constitute arranging or making a State placement. However, the following actions do not constitute State placement:

(i) Providing basic information to individuals about another State's Medicaid program, and information about the availability of health care services and facilities in another State.

(ii) Assisting an individual in locating an institution in another State provided the individual is capable of indicating intent and independently decides to move.

(3) When a competent individual leaves the facility in which the individual is placed by a State, that individual's State of residency for Medicaid purposes is the State where the individual is physically located.

(4) Where placement is initiated by a State because the State lacks a sufficient number of appropriate facilities to provide services to its residents, the State making the placement is the individual's State of residence for Medicaid purposes.

(f) *Individuals receiving title IV-E payments.* For individuals of any age who are receiving Federal payment for foster care and adoption assistance under title IV-E of the Social Security Act, the State of residence is the State where the child lives.

(g) *Individuals under age 21.* (1) For any individual who is emancipated from his or her parents or who is married and capable of indicating intent, the State of residence is the State where the individual is living with the intention to remain there permanently or for an indefinite period.

(2) For any individual not residing in an institution as defined in paragraph (b) whose Medicaid eligibility is based on blindness or disability, the State of residence is the State in which the individual is living.

(3) For any other non-institutionalized individual not subject to paragraph (h)(1) or (h)(2) of this section, the State of residence is determined in accordance with 45 CFR 233.40, the rules governing residence under the AFDC program.

(4) For any institutionalized individual who is neither married nor emancipated, the State of residence is—

(i) The parents' or legal guardian's current State of residence at the time of placement; or

(ii) The current State of residence of the parent or legal guardian who files the application, if the individual is institutionalized in that State. If a legal guardian has been appointed and the parental rights are terminated, the State of residence of the guardian is used instead of the parent's.

(iii) The State of residence of the individual or party who files an application is used if the individual has been abandoned by his or her parent(s), does not have a legal guardian and is institutionalized in that State.

(h) *Individuals age 21 and over.* (1) For any individual not residing in an institution as defined in paragraph (b), the

State of residence is the State where the individual is—

(i) Living with the intention to remain there permanently or for an indefinite period (or if incapable of stating intent, where the individual is living); or

(ii) Living and which the individual entered with a job commitment or seeking employment (whether or not currently employed).

(2) For any institutionalized individual who became incapable of indicating intent before age 21, the State of residence is—

(i) That of the parents applying for Medicaid on the individual's behalf, if the parents reside in separate States;

(ii) The parent's or legal guardian's State of residence at the time of placement; or

(iii) The current State of residence of the parent or legal guardian who files the application, if the individual is institutionalized in that State. If a legal guardian has been appointed and parental rights are terminated, the State of residence of the guardian is used instead of the legal parent's.

(iv) The State of residence of the individual or party who files an application is used if the individual has been abandoned by his or her parent(s), does not have a legal guardian and is institutionalized in that State.

(3) For any institutionalized individual who became incapable of indicating intent at or after age 21, the State of residence is the State in which the individual is physically present, except where another State makes a placement.

(4) For any other institutionalized individual, the State of residence is the State where the individual is living with the intention to remain there permanently or for an indefinite period.

(i) *Specific prohibitions.* (1) The agency may not deny Medicaid eligibility because an individual has not resided in the State for a specified period.

(2) The agency may not deny Medicaid eligibility to an individual in an institution, who satisfies the residency rules set forth in this section, on the grounds that the individual did not establish residence in the State before entering the institution.

(3) The agency may not deny or terminate a resident's Medicaid eligibility because of that person's temporary absence from the State if the person intends to return when the purpose of the absence has been accomplished, unless another State has determined that the person is a resident there for purposes of Medicaid.

(j) *Interstate agreements.* A State may have a written agreement with another State setting forth rules and procedures resolving cases of disputed residency. These agreements may establish criteria other than those specified in paragraphs (c) through (h) of this section, but must not include criteria that result in loss of residency in both States or that are prohibited by paragraph (i) of this section. The agreements must contain a procedure for providing Medicaid to individuals pending resolution of the case.

States may use interstate agreements for purposes other than cases of disputed residency to facilitate administration of the program, and to facilitate the placement and adoption of title IV-E individuals when the child and his or her adoptive parent(s) move into another State.

(k) *Continued Medicaid for institutionalized recipients.* An agency is providing Medicaid to an institutionalized recipient who, as a result of this section, would be considered a resident of a different State—

(1) The agency must continue to provide Medicaid to that recipient from June 24, 1983 until July 5, 1984 unless it makes arrangements with another State of residence to provide Medicaid at an earlier date; and

(2) Those arrangements must not include provisions prohibited by paragraph (g) of this section.

(l) *Cases of disputed residency.* Where two or more States cannot resolve which State is the State of residence, the State where the individual is physically located is the State of residence.

[49 FR 13533, Apr. 5, 1984, as amended at 55 FR 48610, Nov. 21, 1990]

§ 436.404 Applicant's choice of category.

The agency must allow an individual who would be eligible under more than

one category to have his eligibility determined for the category he selects.

§ 436.406 Citizenship and alienage.

(a) The agency must provide Medicaid to otherwise eligible residents of the United States who are—

(1) Citizens; or

(2) Aliens lawfully admitted for permanent residence or permanently residing in the United States under color of law, as defined in § 436.408 of this part;

(3) Aliens granted lawful temporary resident status under sections 245A and 210A of the Immigration and Nationality Act if the individual is aged, blind, or disabled as defined in section 1614(a)(1) of the Act, under 18 years of age, or a Cuban/Haitian entrant as defined in section 501 (e)(1) and (2)(A) of Pub. L. 96-422; or

(4) Aliens granted lawful temporary resident status under section 210 of the Immigration and Nationality Act unless the alien would, but for the 5-year bar to receipt of AFDC contained in such section, be eligible for AFDC.

(b) The agency must only provide emergency services (as defined for purposes of section 1916(a)(2)(D) of the Social Security Act), and services for pregnant women as defined in section 1916(a)(2)(B) of the Social Security Act to otherwise eligible residents of the United States not described in paragraphs (a)(3) and (a)(4) of this section who have been granted lawful temporary or lawful permanent resident status under section 245A, 210 or 210A of the Immigration and Nationality Act for five years from the date lawful temporary resident status was granted.

(c) The agency must provide payment for the services described in § 440.255 to residents of the State who otherwise meet the eligibility requirements of the State plan (except for receipt of AFDC, SSI, or State Supplementary payments and the presentation of a social security number) but who do not meet the requirements of paragraph (a) of this section.

(d) The limitations on eligibility set forth in paragraph (b) of this section do not apply after 5 years from the date this alien was granted lawful temporary resident status.

[55 FR 36820, Sept. 7, 1990]

§ 436.408 Categories of aliens who are permanently residing in the United States under color of law.

This section describes aliens that the agency must accept as permanently residing in the United States under color of law and who may be eligible for Medicaid.

(a) An individual may be eligible for Medicaid if the individual is an alien residing in the United States with the knowledge and permission of the Immigration and Naturalization Services (INS) and the INS does not contemplate enforcing the alien's departure. The INS does not contemplate enforcing the alien's departure if it is the policy or practice of INS not to enforce the departure of aliens in the same category, or if from all the facts and circumstances in the case it appears that INS is otherwise permitting the alien to reside in the United States indefinitely, as determined by verifying the alien's status with INS.

(b) Aliens who are permanently residing in the United States under color of law are listed below. None of the categories includes applicants for an Immigration and Naturalization Service status other than those applicants listed in paragraph (b)(6) of this section, or those covered under paragraph (b)(16) of this section. None of the categories allows Medicaid eligibility for non-immigrants: for example, students or visitors. Also listed are the most common documents that the INS provides to aliens in these categories.

(1) Aliens admitted to the United States pursuant to 8 U.S.C. 1153(a)(7), (section 203(a)(7) of the Immigration and Nationality Act). Ask for a copy of INS Form I-94 endorsed "Refugee-conditional Entry";

(2) Aliens, including Cuban/Haitian entrants, paroled in the United States pursuant to 8 U.S.C. 1182(d)(5) section 212(d)(5) of the Immigration and Nationality Act. Ask for a copy of INS Form I-94 with notation that the alien was paroled pursuant to section 212(d)(5) of the Immigration and Nationality Act. For Cuban/Haitian entrants ask for a copy of INS Form I-94 stamped Cuban/Haitian entrant (Status Pending) reviewable January 15, 1981.

(Although the forms bear this notation, Cuban/Haitian entrants are admitted under section 212(d)(5) of the Immigration and Nationality Act.);

(3) Aliens residing in the United States pursuant to an indefinite stay of deportation. Ask for an Immigration and Naturalization Service letter with this information or INS Form I-94 with such a notation;

(4) Aliens residing in the United States pursuant to an indefinite voluntary departure. Ask for an Immigration and Naturalization Service letter or INS Form I-94 showing that a voluntary departure has been granted for an indefinite time period;

(5) Aliens on whose behalf an immediate relative petition has been approved and their families covered by the petition who are entitled to voluntary departure (under 8 CFR 242.5(a)(2)(vi)) and whose departure the Immigration and Naturalization Service does not contemplate enforcing. Ask for a copy of INS Form I-94 or INS Form I-210 or a letter showing this status;

(6) Aliens who have filed applications for adjustment of status pursuant to section 245 of the Immigration and Nationality Act (8 U.S.C. 1255) that the Immigration and Naturalization Service has accepted as “properly filed” (within the meaning of 8 CFR 245.2(a)(1) or (2)) and whose departure the Immigration and Naturalization Service does not contemplate enforcing. Ask for a copy of INS Form I-94 or I-181 or a passport properly endorsed;

(7) Aliens granted stays of deportation by court order, statute or regulation, or by individual determination of the Immigration and Naturalization Service pursuant to section 106 of the Immigration and Nationality Act (8 U.S.C. 1105a) or relevant Immigration and Naturalization Service instructions, whose departure that agency does not contemplate enforcing. Ask for a copy of INS Form I-94 or a letter from the Immigration and Naturalization Service, or a copy of a court order establishing the alien’s status;

(8) Aliens granted asylum pursuant to section 208 of the Immigration and Nationality Act (8 U.S.C. 1158). Ask for a copy of INS Form I-94 and a letter establishing this status;

(9) Aliens admitted as refugees pursuant to section 207 of the Immigration and Nationality Act (8 U.S.C. 1157) or section 203(a)(7) of the Immigration and Nationality Act (8 U.S.C. 1153(a)(7)). Ask for a copy of INS Form I-94 properly endorsed;

(10) Aliens granted voluntary departure pursuant to section 242(b) of the Immigration and Nationality Act (8 U.S.C. 1252(b)) or 8 CFR 242.5 whose departure the Immigration and Naturalization Service does not contemplate enforcing. Ask for a copy of INS Form I-94 or I-210 bearing a departure date;

(11) Aliens granted deferred action status pursuant to Immigration and Naturalization Service Operations Instruction 103.1(a)(ii) prior to June 15, 1984 or § 242.1(a)(22) issued June 15, 1984 and later. Ask for a copy of INS Form I-210 or a letter showing that departure has been deferred;

(12) Aliens residing in the United States under orders of supervision pursuant to section 242 of the Immigration and Nationality Act (8 U.S.C. 1152(d)). Ask for a copy of Form I-220 B;

(13) Aliens who have entered and continuously resided in the United States since before January 1, 1972 (or any date established by section 249 of the Immigration and Nationality Act, 8 U.S.C. 1259). Ask for any proof establishing this entry and continuous residence;

(14) Aliens granted suspension of deportation pursuant to section 244 of the Immigration and Nationality Act (8 U.S.C. 1254) and whose departure the Immigration and Naturalization Service does not contemplate enforcing. Ask for an order from the Immigration judge;

(15) Aliens whose deportation has been withheld pursuant to section 243(h) of the Immigration and Nationality Act (8 U.S.C. 1253(h)). Ask for an order from an immigration judge showing that deportation has been withheld; or

(16) Any other aliens living in the United States with the knowledge and permission of the Immigration and Naturalization Service and whose departure that agency does not contemplate enforcing, including permanent non-immigrants as established by

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Public Law 99-239, and persons granted Extended Voluntary Departure due to conditions in the alien's home country based on a determination by the Secretary of State.

[55 FR 36821, Sept. 7, 1990, as amended at 56 FR 10807, Mar. 14, 1991; 58 FR 4908, Jan. 19, 1993]

Subpart F—Categorical Requirements for Medicaid Eligibility

§ 436.500 Scope.

This subpart prescribes categorical requirements for determining the eligibility of both categorically needy and medically needy individuals specified in subparts B, C, and D of this part.

DEPENDENCY

§ 436.510 Determination of dependency.

For families with dependent children who are not receiving AFDC, the agency must use the definitions and procedures used under the State's AFDC plan to determine whether—

(a) An individual is a dependent child because he is deprived of parental support or care; and

(b) An individual is an eligible member of a family with dependent children.

[43 FR 45218, Sept. 29, 1978, as amended at 58 FR 4936, Jan. 19, 1993]

AGE

§ 436.520 Age requirements for the aged.

The agency must not impose an age requirement of more than 65 years.

[58 FR 4936, Jan. 19, 1993]

§ 436.522 Determination of age.

(a) In determining age, the agency must use the common law method (under which an age is reached the day before the anniversary of birth) or the popular usage method (under which a specific age is reached on the anniversary of birth), whichever is used under the corresponding State plan for OAA, AFDC, AB, APTD, or AABD.

(b) The agency may use an arbitrary date, such as July 1, for determining an

individual's age if the year, but not the month, of his birth is known.

[58 FR 4936, Jan. 19, 1993]

BLINDNESS

§ 436.530 Definition of blindness.

(a) *Definition.* The agency must use the definition of blindness that is used in the State plan for AB or AABD.

(b) *State plan requirement.* The State plan must contain the definition of blindness, expressed in ophthalmic measurements.

§ 436.531 Determination of blindness.

In determining blindness—

(a) A physician skilled in the diseases of the eye or an optometrist, whichever the individual selects, must examine him, unless both of the applicant's eyes are missing;

(b) The examiner must submit a report of examination to the Medicaid agency; and

(c) A physician skilled in the diseases of the eye (for example, an ophthalmologist or an eye, ear, nose, and throat specialist) must review the report and determine on behalf of the agency—

(1) Whether the individual meets the definition of blindness; and

(2) Whether and when reexaminations are necessary for periodic redeterminations of eligibility, as required under § 435.916 of this subchapter. Blindness is considered to continue until the reviewing physician determines that the recipient's vision no longer meets the definition.

[43 FR 45218, Sept. 29, 1978, as amended at 44 FR 17939, Mar. 23, 1979]

DISABILITY

§ 436.540 Definition of disability.

(a) *Definition.* The agency must use the definition of permanent and total disability that is used in the State plan for APTD or AABD. (See 45 CFR 233.80(a)(1) for the Federal recommended definition of permanent and total disability.)

(b) *State plan requirement.* The State plan must contain the definition of permanent and total disability.

§ 436.541 Determination of disability.

(a) *Basic requirements.* (1) At a minimum, the agency must use the review team, information, and evidence requirements specified in paragraph (b) through (d) of this section in making a determination of disability.

(2) If the requirements or determining disability under the State's APTD or AABD program are more restrictive than the minimum requirements specified in this section, the agency must use the requirements applied under the APTD or AABD program.

(b) The agency must obtain a medical report and a social history for individuals applying for Medicaid on the basis of disability. The medical report must include a diagnosis based on medical evidence. The social history must contain enough information to enable the agency to determine disability.

(c) A physician and social worker, qualified by professional training and experience, must review the medical report and social history and determine on behalf of the agency whether the individual meets the definition of disability. The physician must determine whether and when reexaminations will be necessary for periodic redeterminations of eligibility as required under § 435.916 of this subchapter.

(d) In subsequently determining disability, the physician and social worker must review reexamination reports and the social history and determine whether the individual continues to meet the definition. Disability is considered to continue until this determination is made.

[54 FR 50762, Dec. 11, 1989]

Subpart G—General Financial Eligibility Requirements and Options

§ 436.600 Scope.

This subpart prescribes:

(a) General financial requirements and options for determining the eligibility of both categorically needy and medically needy individuals specified in subparts B, C, and D of this part. Subparts H and I of this part prescribe additional financial requirements.

(b) [Reserved]

[58 FR 4936, Jan. 19, 1993, as amended at 59 FR 43053, Aug. 22, 1994]

§ 436.601 Application of financial eligibility methodologies.

(a) *Definitions.* For purposes of this section, *cash assistance financial methodologies* refers to the income and resources methodologies of the OAA, AFDC, AB, APTD, and AABD programs.

(b) *Basic rule for use of cash assistance methodologies.* Except as specified in paragraphs (c) and (d) of this section, in determining financial eligibility of individuals as categorically and medically needy, the agency must apply the cash assistance financial methodologies and requirements of the cash assistance program that is most closely categorically related to the individual's status.

(c) *Financial responsibility of relatives.* The agency must use the requirements for financial responsibility of relatives specified in § 436.602.

(d) *Use of less restrictive methodologies than under cash assistance program.* (1) At State option, and subject to the conditions of paragraphs (d)(2) through (d)(5) of this section, the agency may apply income and resource methodologies that are less restrictive than the cash assistance methodologies in determining financial eligibility of the following groups:

(i) Qualified pregnant women and children under the mandatory categorically needy group under § 436.120;

(ii) Low-income pregnant women, infants, and children specified in section 1902(a)(10)(i) (IV), (VI), and (VII) of the Act;

(iii) Qualified Medicare beneficiaries specified in sections 1902(a)(10)(E) and 1905(p) of the Act;

(iv) Optional categorically needy individuals under groups established under subpart C of this part and section 1902(a)(10)(A)(ii) of the Act; and

(v) Medically needy individuals under groups established under subpart D of this part and section 1902(a)(10)(C)(i)(III) of the Act.

(2) The income and resource methodologies that an agency elects to apply to groups of individuals under paragraph (c)(1) of this section may be

less restrictive, but no more restrictive, than:

(i) For groups of aged, blind, and disabled individuals, the SSI methodologies; or

(ii) For all other groups, the methodologies under the State plan most closely categorically related to the individual's status.

(3) A financial methodology is considered to be no more restrictive if, by using the methodology, additional individuals may be eligible for Medicaid and no individuals who are otherwise eligible are by use of that methodology made ineligible for Medicaid.

(4) The less restrictive methodology applied under this section must be comparable for all persons within each category of assistance (aged, or blind, or disabled, or AFDC-related) within each eligibility group. For example, if the agency chooses to apply a less restrictive income or resource methodology to aged individuals, it must apply that methodology to an eligibility group of all aged individuals within the selected group.

(5) The application of the less restrictive income and resource methodologies permitted under this section must be consistent with the limitations and conditions on FFP specified in subpart K of this part.

(e) [Reserved]

(f) *State plan requirements.* (1) The State plan must specify that, except to the extent precluded by § 436.602 in determining financial eligibility of individuals, the agency will apply the cash assistance financial methodologies and requirements, unless the agency chooses to apply less restrictive income and resource methodologies, in accordance with paragraph (d) of this section.

(2) If the agency chooses to apply less restrictive income and resource methodologies, the State plan must specify:

(i) The less restrictive methodologies that will used; and

(ii) The eligibility groups or groups to which the less restrictive methodologies will be applied.

[58 FR 4936, Jan. 19, 1993, as amended at 59 FR 43053, Aug. 22, 1994]

§ 436.602 Financial responsibility of relatives and other individuals.

(a) Subject to the provisions of paragraphs (b) and (c) of this section, in determining financial responsibility of relatives and other persons for individuals under Medicaid, the agency must use the following financial eligibility requirements and methodologies.

(1) Except for a spouse of an individual or a parent for a child who is under age 21 or blind or disabled, the agency must not consider income and resources of any relative as available to an individual.

(2) In relation to individuals under 21 (as described in section 1905(a)(i) of the Act), the financial responsibility requirements and methodologies include considering the income and resources of parents or spouses whose income and resources would be considered if the individual under age 21 were dependent under the State's approved AFDC plan, whether or not they are actually contributed. These requirements and methodologies must be applied in accordance with provisions of the State's approved AFDC plan.

(3) When a couple ceases to live together, the agency must count only the income and resources of the individual in determining his or her eligibility, beginning the first month following the month the couple ceases to live together.

(b) The agency may apply income and resource methodologies that are less restrictive than the cash assistance methodologies as specified in the State plan in accordance with § 436.601(d).

(c) [Reserved]

[58 FR 4936, Jan. 19, 1993, as amended at 59 FR 43053, Aug. 22, 1994]

§ 436.604 [Reserved]

§ 436.606 [Reserved]

§ 436.608 Applications for other benefits.

(a) As a condition of eligibility, the agency must require applicants and recipients to take all necessary steps to obtain any annuities, pensions, and retirement and disability benefits to which they are entitled, unless they can show good cause for not doing so.

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(b) Annuities, pensions, and retirement and disability benefits include, but are not limited to, veterans' compensation and pensions, OASDI benefits, railroad retirement benefits, and unemployment compensation.

[43 FR 45218, Sept. 29, 1978. Redesignated at 58 FR 4937, Jan. 19, 1993]

§ 436.610 Assignment of rights to benefits.

(a) As a condition of eligibility, the agency must require legally able applicants and recipients to:

(1) Assign rights to the Medicaid agency to medical support and to payment for medical care from any third party;

(2) Cooperate with the agency in establishing paternity and in obtaining medical support and payments, unless the individual establishes good cause for not cooperating, and except for individuals described in section 1902(l)(1)(A) of the Act (poverty level pregnant women), who are exempt from cooperating in establishing paternity and obtaining medical support and payments from, or derived from, the father of the child born out of wedlock; and

(3) Cooperate in identifying and providing information to assist the Medicaid agency in pursuing third parties who may be liable to pay for care and services under the plan, unless the individual establishes good cause for not cooperating.

(b) The requirements for assignment of rights must be applied uniformly for all groups covered under the plan.

(c) The requirements of paragraph (a) of this section for assignment of rights to medical support and other payments and cooperation in obtaining medical support and payments are effective for medical assistance furnished on or after October 1, 1984. The requirement for cooperation in identifying and providing information for pursuing liable third parties is effective for medical assistance furnished on or after July 1, 1986.

[55 FR 48610, Nov. 21, 1990; 55 FR 52130, Dec. 19, 1990, as amended at 58 FR 4908, Jan. 19, 1993. Redesignated at 58 FR 4937, Jan. 19, 1993]

Subpart H [Reserved]

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Subpart I—Financial Requirements for the Medically Needy

§ 436.800 Scope.

This subpart prescribes financial requirements for determining the eligibility of medically needy individuals under subpart D of this part.

MEDICALLY NEEDEY INCOME STANDARD

§ 436.811 Medically needy income standard: General requirements.

(a) To determine eligibility of medically needy individuals, the agency must use a single income standard for all covered medically needy groups that meets the requirements of this section.

(b) The income standard must take into account the number of persons in the assistance unit. The standard may not diminish by the number of persons in the unit (for example, if the income level in the standard for an assistance unit of two is set at \$400, the income level in the standard for an assistance unit of three may not be less than \$400).

(c) The income standard must be set at an amount that is no lower than the lowest income standard used on or after January 1, 1966, to determine eligibility under the cash assistance programs that are related to the State's covered medically needy group or groups of individuals under § 436.301.

(d) The income standard may vary based on the variations between shelter costs in urban areas and rural areas.

[58 FR 4938, Jan. 19, 1993]

§ 436.814 Medically needy income standard: State plan requirements.

The State plan must specify the income standard for the covered medically needy groups.

[58 FR 4938, Jan. 19, 1993]

MEDICALLY NEEDEY INCOME ELIGIBILITY AND LIABILITY FOR PAYMENT OF MEDICAL EXPENSES

§ 436.831 Income eligibility.

The agency must determine income eligibility of medically needy individuals in accordance with this section.

(a) *Budget periods.* (1) The agency must use budget periods of not more than 6 months to compute income. The agency may use more than one budget period.

(2) The agency must include in the budget period in which income is computed all or part of the 3-month retroactive period specified in §435.914. The budget period can begin no earlier than the first month in the retroactive period in which the individual received covered services.

(3) If the agency elects to begin the first budget period for the medically needy in any month of the 3-month period prior to the date of application in which the applicant received covered services, this election applies to all medically needy groups.

(b) *Determining countable income.* The agency must, to determine countable income, deduct amounts that would be deducted in determining eligibility under the State's approved plan for OAA, AFDC, AB, APTD, or AABD.

(c) *Eligibility based on countable income.* If countable income determined under paragraph (b) of this section is equal to or less than the applicable income standard under §436.814, the individual is eligible for Medicaid.

(d) *Deduction of incurred medical expenses.* If countable income exceeds the income standard, the agency must deduct from income medical expenses incurred by the individual or family or financially responsible relatives that are not subject to payment by a third party. An expense is incurred on the date liability for the expense arises. The agency must determine deductible incurred expenses in accordance with paragraphs (e), (f) and (g) of this section and deduct those expenses in accordance with paragraph (h) of this section.

(e) *Determination of deductible incurred expenses: Required deductions based on kinds of services.* Subject to the provisions of paragraph (g) of this section, in determining incurred medical expenses to be deducted from income, the agency must include the following:

(1) Expenses for Medicare and other health insurance premiums, and deductibles or coinsurance charges, including enrollment fees, copayments,

or deductibles imposed under §447.51 or §447.53 of this chapter;

(2) Expenses incurred by the individual or family or financially responsible relatives for necessary medical and remedial services that are recognized under State law but not included in the plan;

(3) Expenses incurred by the individual or family or by financially responsible relatives for necessary medical and remedial services that are included in the plan, including those that exceed agency limitations on amount, duration or scope of services;

(f) *Determination of deductible incurred expenses: Required deductions based on the age of bills.* Subject to the provisions of paragraph (g) of this section, in determining incurred medical expenses to be deducted from income, the agency must include the following:

(1) For the first budget period or periods that include only months before the month of application for medical assistance, expenses incurred during such period or periods, whether paid or unpaid, to the extent that the expenses have not been deducted previously in establishing eligibility;

(2) For the first prospective budget period that also includes any of the 3 months before the month of application for medical assistance, expenses incurred during such budget period, whether paid or unpaid, to the extent that the expenses have not been deducted previously in establishing eligibility;

(3) For the first prospective budget period that includes none of the months preceding the month of application, expenses incurred during such budget period and any of the 3 preceding months, whether paid or unpaid, to the extent that the expenses have not been deducted previously in establishing eligibility;

(4) For any of the 3 months preceding the month of application that are not includable under paragraph (f)(2) of this section, expenses incurred in the 3-month period that were a current liability of the individual in any such month for which a spenddown calculation is made and that had not been previously deducted from income in establishing eligibility for medical assistance;

(5) Current payments (that is, payments made in the current budget period) on other expenses incurred before the current budget period and not previously deducted from income in any budget period in establishing eligibility for such period; and

(6) If the individual's eligibility for medical assistance was established in each such preceding period, expenses incurred before the current budget period but not previously deducted from income, to the extent that such expenses are unpaid and are:

(i) Described in paragraphs (e)(1) through (e)(3) of this section; and

(ii) Are carried over from the preceding budget period or periods because the individual had a spenddown liability in each such preceding period that was met without deducting all such incurred, unpaid expenses.

(g) *Determination of deductible incurred medical expenses: Optional deductions.* In determining incurred medical expenses to be deducted from income, the agency—

(1) May include medical institutional expenses (other than expenses in acute care facilities) projected to the end of the budget period at the Medicaid reimbursement rate;

(2) May, to the extent determined by the agency and specified in its approved plan, include expenses incurred earlier than the third month before the month of application; and

(3) May set reasonable limits on the amount to be deducted for expenses specified in paragraphs (e)(1), (e)(2), and (g)(2) of this section.

(h) *Order of deduction.* The agency must deduct incurred medical expenses that are deductible under paragraphs (e), (f), and (g) of this section, in the order prescribed under one of the following three options:

(1) *Type of service.* Under this option, the agency deducts expenses in the following order based on type of service:

(i) Cost-sharing expenses as specified in paragraph (e)(1) of this section.

(ii) Services not included in the State plan as specified in paragraph (e)(2) of this section.

(iii) Services included in the State plan as specified in paragraph (e)(3) of this section but that exceed agency

limitations on amount, duration, or scope of services.

(iv) Services included in the State plan as specified in paragraph (e)(3) of this section but that are within agency limitations on amount, duration, or scope of services.

(2) *Chronological order by service date.* Under this option, the agency deducts expenses in chronological order by the date each service is furnished, or in the case of insurance premiums, coinsurance, or deductibles charges the date such amounts are due. Expenses for services furnished on the same day may be deducted in any reasonable order established by the State.

(3) *Chronological order by bill submission date.* Under this option, the agency deducts expenses in chronological order by the date each bill is submitted to the agency by the individual. If more than one bill is submitted at one time, the agency must deduct the bills from income in the order prescribed in either paragraph (h)(1) or (h)(2) of this section.

(i) *Eligibility based on incurred medical expenses.*

(1) Whether a State elects partial or full month coverage, an individual who is expected to contribute a portion of his or her income toward the costs of institutional care or home and community-based services under § 436.832 is eligible on the first day of the applicable budget (spenddown) period—

(i) If his or her spenddown liability is met after the first day of the budget period; and

(ii) If beginning eligibility after the first day of the budget period makes the individual's share of health care expenses under § 436.832 greater than the individual's contributable income determined under this section.

(2) At the end of the prospective period specified in paragraph (f)(2) or (f)(3) of this section and any subsequent prospective period or, if earlier, when any significant change occurs, the agency must reconcile the projected amounts with the actual amounts incurred, or with changes in circumstances, to determine if the adjusted deduction of incurred expenses reduces income to the income standard.

(3) Except as provided in paragraph (i)(1) of this section, if agencies elect partial month coverage, an individual is eligible for Medicaid on the day that the deduction of incurred health care expenses (and of projected institutional expenses if the agency elects the option under paragraph (g)(1) of this section) reduces income to the income standard.

(4) Except as provided in paragraph (i)(1) of this section, if agencies elect full month coverage, an individual is eligible on the first day of the month in which spenddown liability is met.

(5) Expenses used to meet spenddown liability are not reimbursable under Medicaid. Therefore, to the extent necessary to prevent the transfer of an individual's spenddown liability to the Medicaid program, States must reduce the amount of provider charges that would otherwise be reimbursable under Medicaid.

[59 FR 1674, Jan. 12, 1994]

§ 436.832 Post-eligibility treatment of income of institutionalized individuals: Application of patient income to the cost of care.

(a) *Basic rules.* (1) The agency must reduce its payment to an institution, for services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragraphs (c) and (d) of this section from the individual's total income.

(2) The individual's income must be determined in accordance with paragraph (e) of this section.

(3) Medical expenses must be determined in accordance with paragraph (f) of this section.

(b) *Applicability.* This section applies to medically needy individuals in medical institutions and intermediate care facilities.

(c) *Required deductions.* The agency must deduct the following amounts, in the following order, from the individual's total income as determined under paragraph (e) of this section. Income that was disregarded in determining eligibility must be considered in this process.

(1) *Personal needs allowance.* A personal needs allowance that is reasonable in amount for clothing and other

personal needs of the individual while in the institution. This protected personal needs allowance must be at least—

(i) \$30 a month for an aged, blind, or disabled individual, including a child applying for Medicaid on the basis of blindness or disability;

(ii) \$60 a month for an institutionalized couple if both spouses are aged, blind, or disabled and their income is considered available to each other in determining eligibility; and

(iii) For other individuals, a reasonable amount set by the agency, based on a reasonable difference in their personal needs from those of the aged, blind, or disabled.

(2) *Maintenance needs of spouse.* For an individual with only a spouse at home, an additional amount for the maintenance needs of the spouse. This amount must be based on a reasonable assessment of need but must not exceed the higher of—

(i) The amount of the highest need standard for an individual without income and resources under the State's approved plan for OAA, AFDC, AB, APTD, or AABD; or

(ii) The amount of the highest medically needy income standard for one person established under § 436.811.

(3) *Maintenance needs of family.* For an individual with a family at home, an additional amount for the maintenance needs of the family. This amount must—

(i) Be based on a reasonable assessment of their financial need;

(ii) Be adjusted for the number of family members living in the home; and

(iii) Not exceed the highest of the following need standards for a family of the same size:

(A) The standard used to determine eligibility under the State's Medicaid plan, as provided for in § 436.811.

(B) The standard used to determine eligibility under the State's approved AFDC plan.

(4) *Expenses not subject to third party payment.* Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—

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(i) Medicare and other health insurance premiums, deductibles, or co-insurance charges; and

(ii) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.

(d) *Optional deduction: Allowance for home maintenance.* For single individuals and couples, an amount (in addition to the personal needs allowance) for maintenance of the individual's or couple's home if—

(1) The amount is deducted for not more than a 6-month period; and

(2) A physician has certified that either of the individuals is likely to return to the home within that period.

(e) *Determination of income—(1) Option.* In determining the amount of an individual's income to be used to reduce the agency's payment to the institution, the agency may use total income received or it may project total monthly income for a prospective period not to exceed 6 months.

(2) *Basis for projection.* The agency must base the projection on income received in the preceding period, not to exceed 6 months, and on income expected to be received.

(3) *Adjustments.* At the end of the prospective period specified in paragraph (e)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with income received.

(f) *Determination of medical expenses—(1) Option.* In determining the amount of medical expenses to be deducted from an individual's income, the agency may deduct incurred medical expenses, or it may project medical expenses for a prospective period not to exceed 6 months.

(2) *Basis for projection.* The agency must base the estimate on medical expenses incurred in the preceding period, not to exceed 6 months, and medical expenses expected to be incurred.

(3) *Adjustments.* At the end of the prospective period specified in paragraph (f)(1) of this section, or when any significant change occurs, the agency

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must reconcile estimates with incurred medical expenses.

[45 FR 24888, Apr. 11, 1980, as amended at 46 FR 47991, Sept. 30, 1981; 48 FR 5735, Feb. 8, 1983; 53 FR 3597, Feb. 8, 1988; 56 FR 8851, 8854, Mar. 1, 1991; 58 FR 4938, Jan. 19, 1993]

MEDICALLY NEEDEY RESOURCE STANDARD

§ 436.840 Medically needy resource standard: General requirements.

(a) To determine eligibility of medically needy individuals, the Medicaid agency must use a single resource standard that is set at an amount that is no lower than the lowest resource standard used on or after January 1, 1966, to determine eligibility under the cash assistance programs that are related to the State's covered medically needy group or groups of individuals under § 436.301.

(b) The resource standard established under paragraph (a) of this section may not diminish by an increase in the number of persons in the assistance unit. For example, the resource level in the standard for an assistance unit of three may not be less than that set for an assistance unit of two.

[58 FR 4938, Jan. 19, 1993]

§ 436.843 Medically needy resource standard: State plan requirements.

The State plan must specify the resource standard for the covered medically needy groups.

[58 FR 4938, Jan. 19, 1993]

DETERMINING ELIGIBILITY ON THE BASIS OF RESOURCES

§ 436.845 Medically needy resource eligibility.

To determine eligibility on the basis of resources for medically needy individuals, the agency must—

(a) Consider only the individual's resources and those that are considered available to him under the financial responsibility requirements for relatives under § 436.602;

(b) Consider only resources available during the period for which income is computed under § 436.831(a);

(c) Deduct the value of resources that would be deducted in determining eligibility under the State's plan for OAA, AFDC, AB, APTD, or AABD or under

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the State's less restrictive financial methodology specified in the State Medicaid plan in accordance with § 436.601. In determining the amount of an individual's resources for Medicaid eligibility, States must count amounts of resources that otherwise would not be counted under the conditional eligibility provisions of the AFDC program.

(d) Apply the resource standards established under § 436.840.

[43 FR 45218, Sept. 29, 1978, as amended at 46 FR 47992, Sept. 30, 1981; 58 FR 4938, Jan. 19, 1993]

Subpart J—Eligibility in Guam, Puerto Rico, and the Virgin Islands

SOURCE: 44 FR 17939, Mar. 23, 1979, unless otherwise noted.

§ 436.900 Scope.

This subpart sets forth requirements for processing applications, determining eligibility, and furnishing Medicaid.

§ 436.901 General requirements.

The Medicaid agency must comply with all the requirements of part 435, subpart J, of this subchapter, except those specified in § 435.909.

§ 436.909 Automatic entitlement to Medicaid following a determination of eligibility under other programs.

The agency may not require a separate application for Medicaid from an individual if the individual receives cash assistance under a State plan for OAA, AFDC, AB, APTD, or AABD.

Subpart K—Federal Financial Participation (FFP)

§ 436.1000 Scope.

This subpart specifies when, and the extent to which, FFP is available in expenditures for determining eligibility and for Medicaid services to individuals determined eligible under this part, and prescribes limitations and conditions on FFP for those expenditures.

FFP FOR EXPENDITURES FOR DETERMINING ELIGIBILITY AND PROVIDING SERVICES

§ 436.1001 FFP for administration.

(a) FFP is available in the necessary administrative costs the State incurs in—

(1) Determining and redetermining Medicaid eligibility and in providing Medicaid to eligible individuals; and

(2) Determining presumptive eligibility for children and providing services to presumptively eligible children.

(b) Administrative costs include any costs incident to an eye examination or medical examination to determine whether an individual is blind or disabled.

[43 FR 45218, Sept. 29, 1978, as amended at 66 FR 2668, Jan. 11, 2001]

§ 436.1002 FFP for services.

(a) FFP is available in expenditures for Medicaid services for all recipients whose coverage is required or allowed under this part.

(b) FFP is available in expenditures for services provided to recipients who were eligible for Medicaid in the month in which the medical care or services were provided, except that, for recipients who establish eligibility for Medicaid by deducting incurred medical expenses from income, FFP is not available for expenses that are the recipient's liability.

(c) FFP is available in expenditures for services covered under the plan that are furnished—

(1) To children who are determined by a qualified entity to be presumptively eligible;

(2) During a period of presumptive eligibility;

(3) By a provider that is eligible for payment under the plan; and

(4) Regardless of whether the children are determined eligible for Medicaid following the period of presumptive eligibility.

[43 FR 45218, Sept. 29, 1978, as amended at 44 FR 17940, Mar. 23, 1979; 66 FR 2669, Jan. 11, 2001]

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§ 436.1003 Recipients overcoming certain conditions of eligibility.

FFP is available for a temporary period specified in the State plan in expenditures for services provided to recipients who are overcoming certain eligibility conditions, including blindness, disability, continued absence or incapacity of a parent, or unemployment of a parent.

[45 FR 24888, Apr. 11, 1980]

§ 436.1004 Institutionalized individuals.

(a) FFP is not available in expenditures for services provided to—

(1) Individuals who are inmates of public institutions as defined in § 435.1009; or

(2) Individuals under age 65 who are patients in an institution for mental diseases unless they are under age 22 and are receiving inpatient psychiatric services under § 440.160 of this subchapter.

(b) The exclusion of FFP described in paragraph (a) of this section does not apply during that part of the month in which the individual is not an inmate of a public institution or a patient in an institution for mental diseases.

(c) An individual on conditional release or convalescent leave from an institution for mental diseases is not considered to be a patient in that institution. However, such an individual who is under age 22 and has been receiving inpatient psychiatric services under § 440.160 of this subchapter is considered to be a patient in the institution until he is unconditionally released or, if earlier, the date he reaches age 22.

[43 FR 45204, Sept. 29, 1978, as amended at 50 FR 13200, Apr. 3, 1985; 50 FR 38811, Sept. 25, 1985]

§ 436.1005 Definitions relating to institutional status.

For purposes of FFP, the definitions in § 435.1009 of this subchapter apply to this part.

Subpart L—Option for Coverage of Special Groups

SOURCE: 66 FR 2669, Jan. 11, 2001, unless otherwise noted.

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§ 436.1100 Basis and scope.

(a) *Statutory basis.* Section 1920A of the Act allows States to provide Medicaid services to children under age 19 during a period of presumptive eligibility, prior to a formal determination of Medicaid eligibility.

(b) *Scope.* This subpart prescribes the requirements for providing medical assistance to special groups who are not eligible for Medicaid as categorically or medically needy.

PRESUMPTIVE ELIGIBILITY FOR CHILDREN

§ 436.1101 Definitions related to presumptive eligibility period for children.

Application form means at a minimum the form used to apply for Medicaid under the poverty-level-related eligibility groups described in section 1902(l) of the Act or a joint form for children to apply for the State Children's Health Insurance Program and Medicaid.

Period of presumptive eligibility means a period that begins on the date on which a qualified entity determines that a child is presumptively eligible and ends with the earlier of—

(1) In the case of a child on whose behalf a Medicaid application has been filed, the day on which a decision is made on that application; or

(2) In the case of a child on whose behalf a Medicaid application has not been filed, the last day of the month following the month in which the determination of presumptive eligibility was made.

Presumptive income standard means the highest income eligibility standard established under the plan that is most likely to be used to establish the regular Medicaid eligibility of a child of the age involved.

Qualified entity means an entity that is determined by the State to be capable of making determinations of presumptive eligibility for children, and that—

(1) Furnishes health care items and services covered under the approved plan and is eligible to receive payments under the approved plan;

(2) Is authorized to determine eligibility of a child to participate in a

Head Start program under the Head Start Act;

(3) Is authorized to determine eligibility of a child to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990;

(4) Is authorized to determine eligibility of an infant or child to receive assistance under the special nutrition program for women, infants, and children (WIC) under section 17 of the Child Nutrition Act of 1966;

(5) Is authorized to determine eligibility of a child for medical assistance under the Medicaid State plan, or eligibility of a child for child health assistance under the State Children's Health Insurance Program;

(6) Is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801);

(7) Is an elementary or secondary school operated or supported by the Bureau of Indian Affairs;

(8) Is a State or Tribal child support enforcement agency;

(9) Is an organization that—

(i) Provides emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act;

(ii) Is a State or Tribal office or entity involved in enrollment in the program under this title, Part A of title IV, or title XXI; or

(iii) Determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 *et seq.*); and

(10) Any other entity the State so deems, as approved by the Secretary.

Services means all services covered under the plan including EPSDT (see part 440 of this chapter.)

[66 FR 2669, Jan. 11, 2001, as amended at 66 FR 33822, June 25, 2001]

§436.1102 General rules.

(a) The agency may provide services to children under age 19 during one or more periods of presumptive eligibility following a determination made by a

qualified entity that the child's estimated gross family income or, at the State's option, the child's estimated family income after applying simple disregards, does not exceed the applicable income standard.

(b) If the agency elects to provide services to children during a period of presumptive eligibility, the agency must—

(1) Provide qualified entities with application forms for Medicaid and information on how to assist parents, caretakers and other persons in completing and filing such forms;

(2) Establish procedures to ensure that qualified entities—

(i) Notify the parent or caretaker of the child at the time a determination regarding presumptive eligibility is made, in writing and orally if appropriate, of such determination;

(ii) Provide the parent or caretaker of the child with a Medicaid application form;

(iii) Within 5 working days after the date that the determination is made, notify the agency that a child is presumptively eligible;

(iv) For children determined to be presumptively eligible, notify the child's parent or caretaker at the time the determination is made, in writing and orally if appropriate, that—

(A) If a Medicaid application on behalf of the child is not filed by the last day of the following month, the child's presumptive eligibility will end on that last day; and

(B) If a Medicaid application on behalf of the child is filed by the last day of the following month, the child's presumptive eligibility will end on the day that a decision is made on the Medicaid application; and

(v) For children determined not to be presumptively eligible, notify the child's parent or caretaker at the time the determination is made, in writing and orally if appropriate—

(A) Of the reason for the determination; and

(B) That he or she may file an application for Medicaid on the child's behalf with the Medicaid agency; and

(3) Provide all services covered under the plan, including EPSDT.

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(4) Allow determinations of presumptive eligibility to be made by qualified entities on a Statewide basis.

(c) The agency must adopt reasonable standards regarding the number of periods of presumptive eligibility that will be authorized for a child in a given time frame.

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